LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
ALCOHOL AND DRUG PROGRAM ADMINISTRATION FINANCIAL SERVICES DIVISION
MEDI-CAL/METHADONE REIMBURSEMENT

PROVIDER NAME:_____ CONTRACT NO.:_____
ADDRESS:_____ CLAIM PERIOD:_____
CITY:_____ ZIP:_____ DATE PREPARED:_____
SERVICE CATEGORY:_____ PROVIDER NO.:_____
CONTACT PERSON:_____PHONE:_____

PROGRAM TYPE: ALCOHOL ( ) DRUG ( ) PERINATAL ( ) ORIGINAL ( ) SUPPLEMENT ( )

		TOTAL UNITS			GROSS AMOUNT REQUESTED			
SECTION I - GROSS AMOUNT REQUESTED		A *	B *	C (A+B)	D	E(A*D)	F(B*D)	G(E+F)
SERVICE CODE	CODE	Prop. 36 Medi-Cal	Medi-Cal	Total Units	Contract Rate	Prop. 36 Medi-Cal	Medi-Cal	Total Amount
1a Medication/ Visits								
1b Indiv. Counseling								
1c Group Counseling								
1d NTP - LAAM								
1e Total								

	H	I	J
SECTION II - REVENUE	Prop. 36 Medi-Cal	Medi-Cal	Total Amount
2 Grants	$	$	$
3 Client Fees			
4 Insurance			
5 Other			
6 TOTAL REVENUE	$	$	$

	K	L	M
SECTION III - NET AMOUNT REQUESTED	Prop. 36 Medi-Cal	Medi-Cal	Total Amount
7 Gross Amount Requested (Line 1e Column E, F, & G)	$	$	$
8 Total Revenue (Line 6 Column H, I, & J)			
9 NET AMOUNT REQUESTED (LINE 7 MINUS LINE 8)			

Payment on this claim may be delayed or withheld if this request for reimbursement contains any errors or omissions.

_____ _____
Authorized Signature Date

* Must include ADP Form 1584 Drug Medi-Cal eligibility worksheets.

COUNTY USE ONLY

Amount Requested: $_____
Carry Forward Amount: $_____
Total Amount Payable: $_____

By_____Date_____

LIMITED MONTHLY ALLOCATION
Total Amount
Payable: $_____

By_____Date _____